Home Health, Hospice, and Nursing Facility Basics

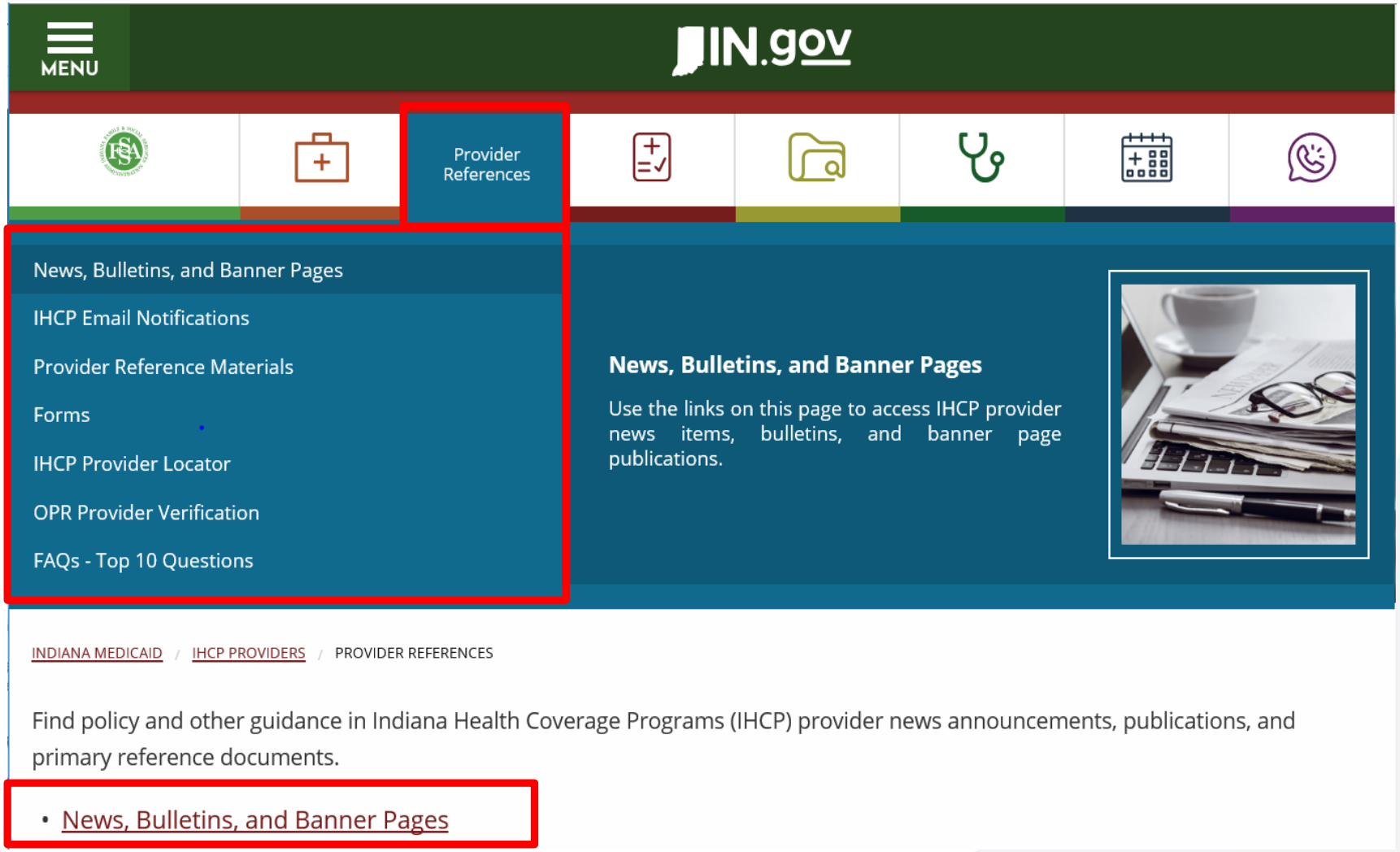
Indiana Health Coverage Programs
DXC Technology
Annual Seminar – October 2019

Agenda

- IHCP Provider Website
- Home Health
- Hospice
- Nursing Facility
- Helpful Tools
- Questions

IHCP Provider Website
(in.gov/medicaid/providers)

How to Keep Informed (in.gov/medicaid/providers)



Provider Reference Materials

INDIANA MEDICAID / IHCP PROVIDERS / PROVIDER REFERENCES

Find policy and other guidance in Indiana Health Coverage Programs (IHCP) provider news announcements, publications, and primary reference documents.

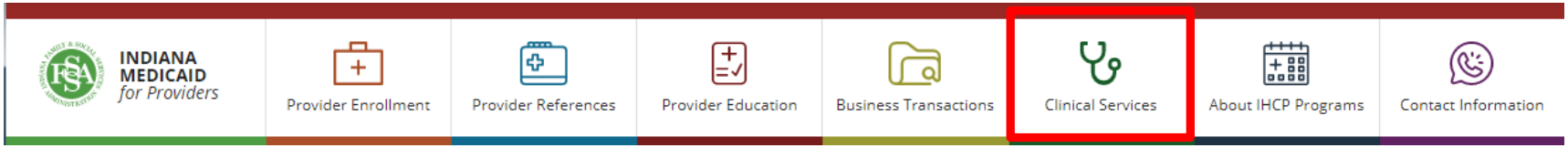
- News, Bulletins, and Banner Pages
  - Current IHCP News
  - Bulletins
  - Banner Pages
- IHCP Email Notifications
- Provider Reference Materials
  - IHCP Provider Reference Modules
  - IHCP Companion Guides
- Forms
- IHCP Provider Locator
- OPR Provider Verification
- FAQs - Top 10 Questions

Provider Reference Modules

	Effective Date*	Version
Service- and Provider-Specific Modules		
Home Health Services	August 1, 2018	3.0
Hospice Services	May 1, 2017	2.0
Long-Term Care	March 1, 2019	4.0

Managed Care

Clinical Services



INDIANA MEDICAID / IHCP PROVIDERS / CLINICAL SERVICES

The Indiana Health Coverage Programs (IHCP) offers information to help providers better serve IHCP members. Guidance focuses on clinical services, particularly for certain provider types and specialties.

- Medical Review Team (MRT)
- Preadmission Screening and Resident Review (PASRR)
- Prior Authorization
  - PA Status Information
- Hospice
  - Hospice Forms
  - Hospice Contacts
- Long Term Care
- Medicaid Rehabilitation Option (MRO)
- Substance Use Disorder (SUD) Treatment
- Nonemergency Medical Transportation
- Notification of Pregnancy (NOP)
- Pharmacy Benefits
  - Pharmacy Services
- Preferred Diabetic Supply List
- Right Choices Program (RCP)

Home Health

Home Health Services

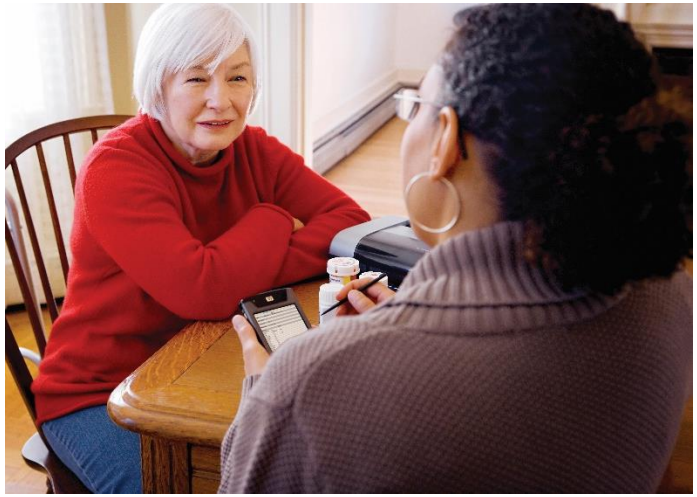
Code	Service Performed By	Billing Unit
Occurrence code 73	[Overhead]	One unit per provider per member per day
Procedure code and modifier 99600 TD	Registered nurse	Hourly
Procedure code and modifier 99600 TE	Licensed practical nurse	Hourly
Procedure code 99600	Home health aide	Hourly
Procedure code G0151	Physical therapist	15-minute increments
Procedure code G0152	Occupational therapist	15-minute increments
Procedure code G0153	Speech-language pathologist	15-minute increments

Home Health
Revenue Code/Procedure Code

Revenue Code	Procedure Code	Revenue Code	Procedure Code
420	G0151	439	G0152
421	G0151	440	G0153
422	G0151	441	G0153
423	G0151	442	G0153
424	97161–97163	443	G0153
429	G0151	444	92521–92524
430	G0152	449	G0153
431	G0152	552	99600 TD, 99600 TE
432	G0152	559	99601, 99602
433	G0152	572	99600
434	97165–97167		

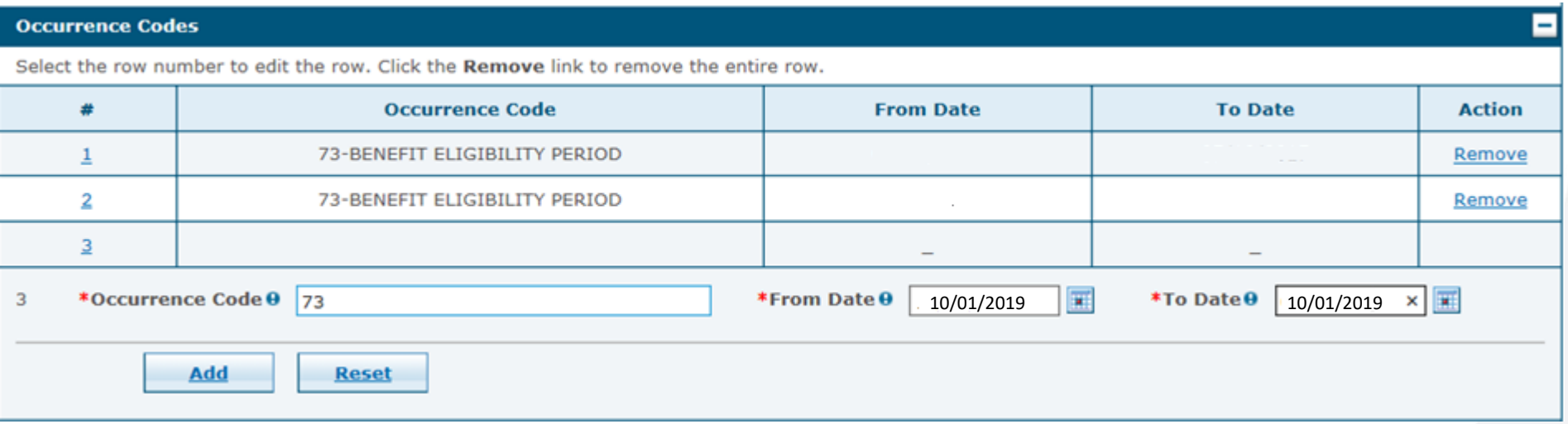
Home Health – Overhead

- For each encounter at home, providers can report only one overhead encounter per member, per day
  - In a multimember situation (for example, husband and wife both treated during same encounter), only one overhead is allowed
- Providers must bill home health overhead with occurrence code 73, as follows:
  - If the dates of service billed are *not consecutive*, enter occurrence code and *the date for each date of service*
  - If the dates of service are *consecutive*, enter occurrence code and *the occurrence span dates*

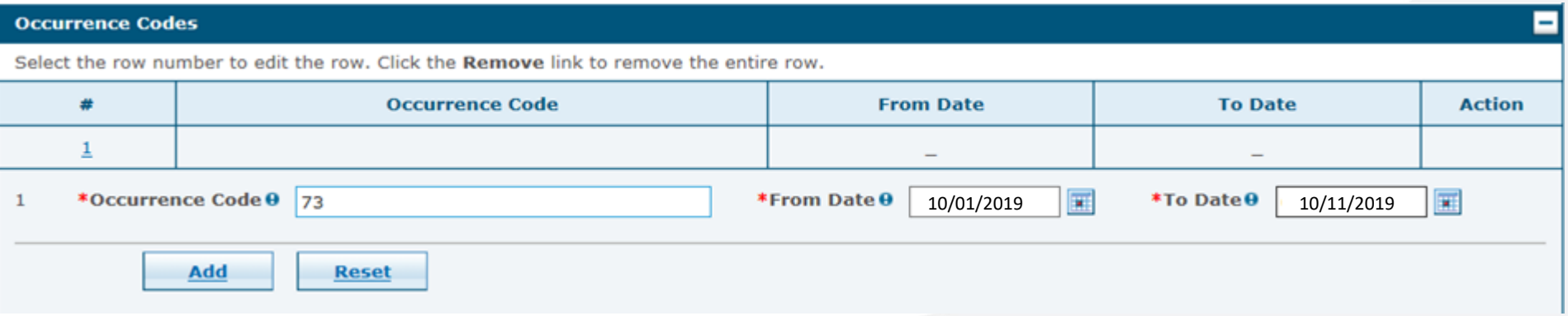


Home Health – Overhead Provider Healthcare Portal

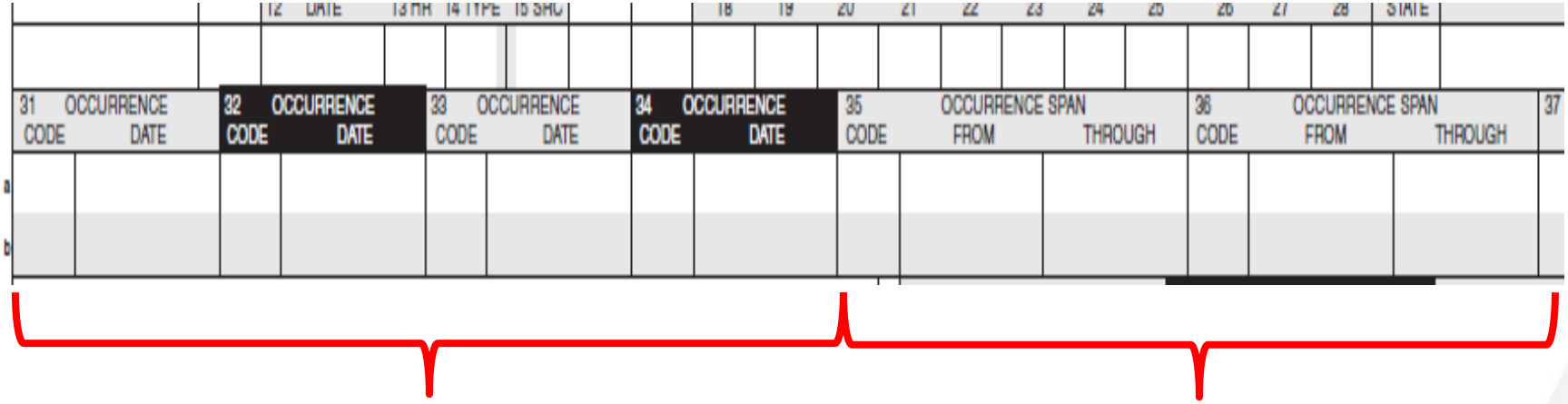
Enter individual service dates if not billing all dates within a time-span



Enter a span of service dates when billing for **ALL** dates within a time-span



Home Health – Overhead Paper Billing



Occurrence code 73 and individual dates

Occurrence code 73 and date span

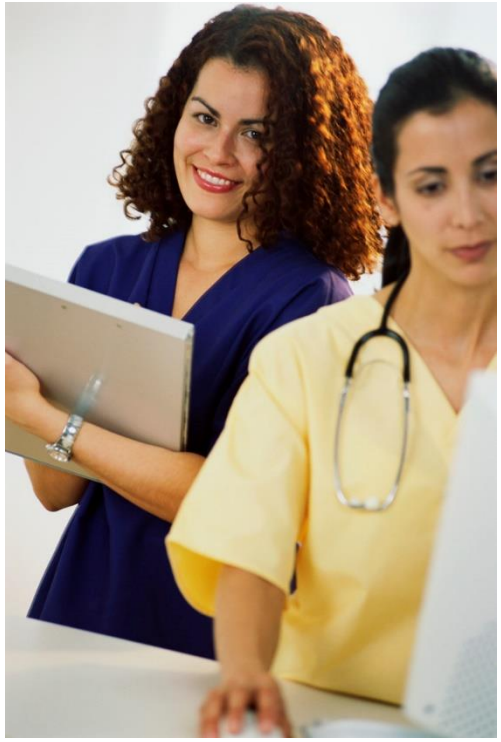
Covered Services

- Home health services include home health nursing, home health aide services, and skilled therapies (physical therapy, occupational therapy, and speech-language pathology)
- IHCP home health benefits include covered services performed by practitioners such as:
  - Registered nurses (RNs)
  - Licensed practical nurses (LPNs)
  - Physical therapists
  - Occupational therapists
  - Speech-language pathologists
  - Home health aides

Telehealth

The IHCP covers telehealth services provided by home health agencies. ***Telehealth services*** are defined as:

- Scheduled remote monitoring of clinical data through technologic equipment in the member's home
- Data is transmitted from the member's home to the home health agency to be read and interpreted by a registered nurse (RN)
- The technologic equipment enables the home health agency to detect minute changes in the member's clinical status, which allows home health agencies to intercede before the member's condition advances and requires emergency intervention or inpatient hospitalization



Home Health – Face-to-Face Policy Requirements

- Documentation of face-to-face encounter is required no more than 90 days before or 30 days after the start of service
- Face-to-face requirement does not apply to Home and Community-Based Services (HCBS) waiver home health services

Prior Authorization

- ***ALL*** home health services require prior authorization (PA)
- PA is provided by **DXC Technology**
  - Refer to bulletin **BT201957** for information about change from Cooperative Managed Care Services to DXC for prior authorization
- An authorized representative of the home health agency submits PA requests for home health agency services, along with supporting documentation, to DXC Technology
- An increase in home health services, except in the case of urgent or emergency services, also requires a written request with supporting documentation of medical necessity
- The best way to request PA is via the Provider Healthcare Portal
- PA requests can still be made by phone or fax

Home Health – Prior Authorization Bypass

Bypassing PA:

- Services within 30 days of hospital discharge with physician order for home health service
  - If services will exceed 30 days, a face-to-face is required
- RN, LPN, or home health aide services not to exceed 120 hours
- Any combination of therapy services not to exceed 30 units
- Enter occurrence code 42 and the date of inpatient discharge on each claim to bypass the prior authorization requirement

Home Health – Managed Care

For Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise members, bill the appropriate managed care entity (MCE):

- Anthem
- CareSource
- MDwise
- MHS

Providers are advised to check eligibility at least the 1st and the 15th of each month

Home Health – Frequently Asked Question

Q: Can a member have home health and hospice at the same time?

A: Yes – in specific circumstances when:

- Diagnosis code for the terminal and the nonterminal illness are not related
- Thorough explanation of the medical necessity is included in the PA request

The hospice provider must submit the hospice plan of care and the home health plan of care to the Indiana Health Coverage Program Fee-for-service prior authorization vendor, DXC, to ensure a comprehensive review

Home Health for Hospice Members

If a member has elected **hospice** while also receiving **home health**:

- Contact your DXC regional Provider Relations Field Consultant
- It is required to have DXC approve payment of both types of services
  - If approved, the DXC Regional Provider Field Consultant will need to obtain a paper claim form and special batch the claim for processing to override the duplicate services edit.

Electronic Visit Verification (EVV)

- The *21st Century Cures Act* requires Medicaid providers of home health services to use an electronic visit verification (EVV) system to document services rendered
  - Use of an EVV system to document home health services must be implemented by January 1, 2023
- Federal law requires that providers use the EVV system to document the following information:
  - Date of service
  - Location of service
  - Individual providing service
  - Type of service
  - Individual receiving service
  - Time the service begins and ends
- For detailed information about EVV, refer to the *Electronic Visit Verification* web page at in.gov/medicaid/providers

Hospice

Hospice – Election

- Member must elect hospice services by completing a *Medicaid Hospice Election State Form 48737 (R2/1-12)*
  - Form can be downloaded from the *Forms* page at in.gov/medicaid/providers

Hospice – Election

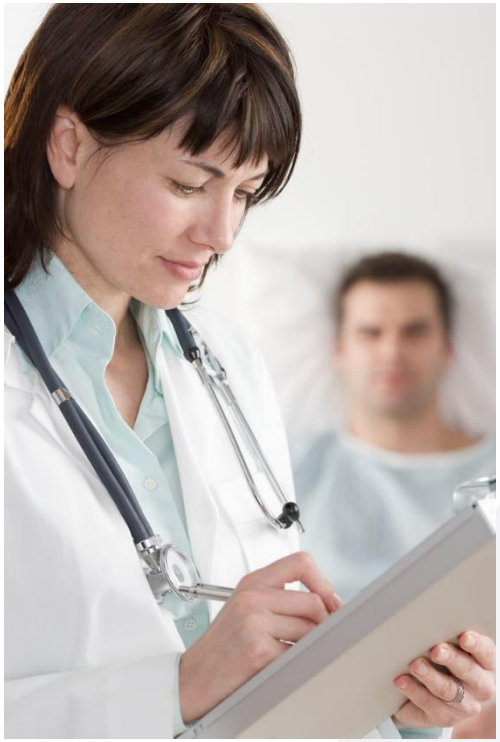
- Indicates a particular hospice provider – According to *42 USC 1395d(d)(2)* and *405 IAC 5-34-6(b)*, election to the hospice benefit requires the member to waive the following:
  - Other forms of healthcare for treatment of the terminal illness for which hospice care was elected or for treatment of a condition related to the terminal illness
  - Services provided by another provider equivalent to the care provided by the elected hospice provider
  - Hospice services other than those provided by the elected hospice provider or its contractors

Hospice – General Information

- To be eligible for program services, IHCP members must:
  - Have a prognosis of 6 months or less to live
  - Elect hospice services
- Available hospice services include, but are not limited to:
  - Palliative care for physical, psychological, social, and spiritual needs of the patient
- Hospice providers can provide hospice care to an IHCP member:
  - In an inpatient setting
  - In an nursing facility setting
  - In the member's home

Hospice – Election for Members 20 Years or Younger

- Members 20 years or younger:
  - Not required to waive other forms of healthcare for treatment of the terminal illness
  - Concurrent hospice care and curative care benefits available
  - Palliative treatment and management of terminal condition supervised by hospice provider
  - Curative care services covered separately by the IHCP



Hospice – Election for Members 20 Years or Younger

- Hospice plan of care and a curative plan of care must both be submitted for PA review
  - *Medicaid Hospice Plan of Care for Curative Care – Members 20 Years and Younger* – Available on the *Forms* page at in.gov/medicaid/providers
- No changes to hospice billing
  - Curative care services reimbursed separately

Hospice – Service Intensity Add-On (SIA)

- Service Intensity Add-on (SIA) is billed with revenue codes 551 or 561
- Must be billed as detail line items on the claim
- Must include discharge status codes 20, 40, 41, or 42

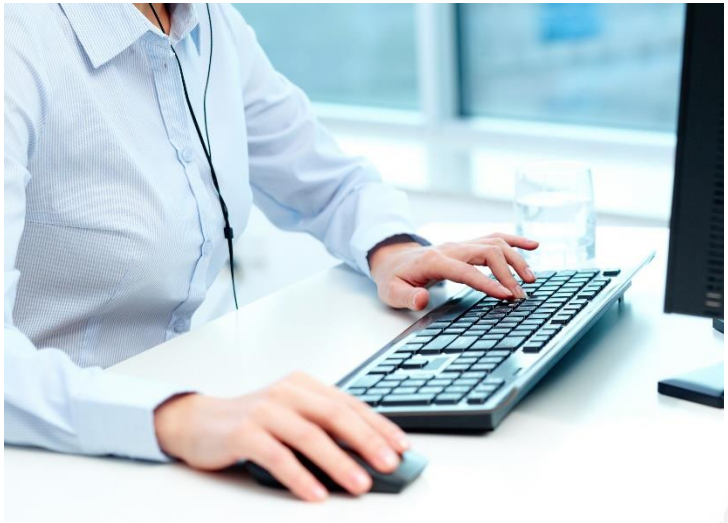
Hospice – Aid Categories Not Eligible for Hospice Benefit

Aid Categories not eligible for the hospice benefit:

- 590 Program
- Children's Special Health Care Services (CSHCS)
- Aid to Residents in County Homes (ARCH)
- Qualified Medicare Beneficiaries Only (QMB-Only)
- Specified Low-Income Medicare Beneficiaries Only (SLMB-Only)
- Emergency Services Only (Package E)
- Limited benefits to pregnant women under Presumptive Eligibility for Pregnant Women (PEPW)
- Family Planning Eligibility Program

Hospice – Right Choices Program

- Managed Care members must be disenrolled from Right Choices Program (RCP) to receive hospice benefits
- On receipt of hospice election paperwork, DXC contacts the RCP Administrator to request that the member be disenrolled from the RCP
  - Hospice providers should follow up with DXC staff to confirm RCP disenrollment is in process



Hospice – Healthy Indiana Plan

- Hospice providers must identify the Healthy Indiana Plan (HIP) member's MCE
- Prior authorization and claims payment must be directed to the HIP member's MCE
- A hospice provider must ensure that it is a HIP-enrolled provider within the HIP member's plan MCE
- Specific information about HIP and the distinct MCE that administers HIP can be found on the *Healthy Indiana Plan* website at in.gov/fssa/hip

Hospice – Hoosier Care Connect

All covered hospice benefits for Hoosier Care Connect members are the responsibility of the managed care entity (MCE) with which the member is enrolled

- Members remain enrolled with their MCE for the duration of the hospice period
- Prior authorization (PA) should be obtained through the appropriate MCE
- Covered services include routine home care, continuous home care, inpatient respite care, and general inpatient care

Providers are reminded to verify the member has the appropriate Hospice level of care.

Hospice – Hoosier Healthwise

- In-home and institutional hospice care are not covered benefits for Hoosier Healthwise members assigned to an MCE
  - Hoosier Healthwise members must be disenrolled from their managed care plan and enrolled in Traditional Medicaid to receive hospice care

Hospice – Hoosier Healthwise

- For members to be disenrolled from their managed care plan:
  - Fax member disenrollment request to the IHCP PA contractor, DXC, at 317-810-4488
  - It is imperative that hospice providers type **Hospice Member Disenrollment from Managed Care Plan** in the subject line of the fax
  - A follow up phone call to DXC is recommended to verify receipt of fax
- DXC hospice analysts contact Maximus on the same day
- The hospice provider may start billing the IHCP the day after the individual is disenrolled from their managed care plan

Nursing Facility

Nursing Facility

Nursing facility (NF) services are available to members who meet the threshold of nursing care needs required for admission to, or continued stay in, an IHCP-certified facility:

- Preadmission screening (PAS) for long-term care services is required for **placement** in an NF or Preadmission Screening and Resident Review (PASRR) for a **continued stay**
- To access the required documents, visit the FSSA website
- Package C members do not have coverage for nursing facility care

An approved Nursing Facility Level of Care is required for IHCP reimbursement

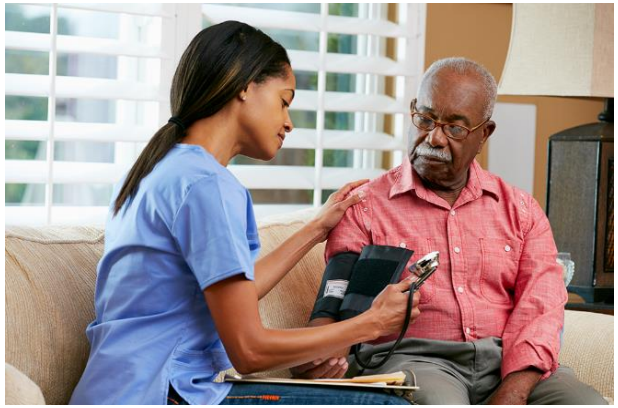
NF – Revenue Codes

- Room and board is billed as follows:
  - 110 – *Room and board private*
  - 120 – *Room and board semiprivate (two beds)*
- Bed-hold days are not reimbursed but should be reported:
  - 180 – *Bed-hold days*
  - 183 – *Therapeutic bed-hold days*
  - 185 – *Hospital bed-hold day*

Even though bed-hold days are not payable, they should be present on the claim to accurately reflect member status.

NF – Discharge Status Codes

- The patient status code on the claim form is used to close the member's level of care (LOC)
- This process eliminates the need to submit written discharge information to the FSSA
- Use of incorrect status codes:
  - Can result in overpayments, which result in recoupment
  - Prevents members from receiving services, such as home health services and pharmacy prescriptions, after discharge from the NF



*When billing for the final days in the NF, **all** days must be listed through discharge for claims to close the LOC.*

NF and Hospice

- NF responsibility
  - Have an approved PAS, with a Medicaid level of care effective date
    - Required for IHCP reimbursement
    - NF does not bill for room and board
- Hospice responsibility
  - Submit claims with the appropriate revenue code indicating member is in an NF
  - Submit claims with the appropriate discharge status code for hospice services
  - Retro-rate adjustments
  - Hospice claims billed under bill type 822, and for hospice revenue codes 653, 654, 659, 183, and 185, are automatically mass adjusted
  - Retro-rate mass adjustment internal claim numbers (ICNs)/ Claim IDs begin with 55

NF – Managed Care

If the NF notifies the MCE within 72 hours of admission, the MCE is liable for charges for a set number of days **from the date of admission**, dependent upon the managed care program in which the member is enrolled:

- – Up to 30 days from the date of admission for Hoosier Care Connect
- – Up to 60 days from the date of admission for Hoosier Healthwise
- – Up to 100 days from the date of admission for HIP

NF – Frequently Asked Questions

- Why did my NF claim deny when mass adjusted to apply a retroactive rate?
  - Level-of-care (LOC) eligibility could have been inadvertently altered
  - Discharge status code on claims previously submitted is incorrect
- Patient liability appears to be deducted twice during the retro-rate adjustment – why?
  - Liability may be deducted on a different claim for the same month during retro-rate adjustment
  - Verify retro-rate adjustments for the entire month

Level-of-Care Help

When and where to get LOC assistance:

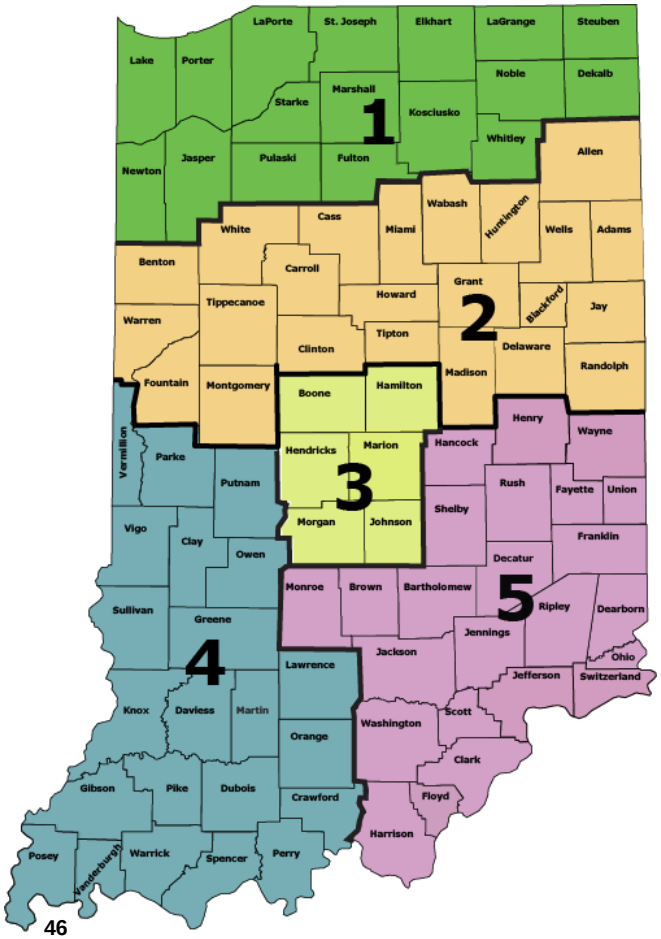
- Assistance when LOC is incorrect or closed erroneously
- If LOC approval was received and not appearing on member eligibility

pasrr@fssa.in.gov

Helpful Tools

Helpful Tools

Provider Relations Consultants



REGION	FIELD CONSULTANT	EMAIL	TELEPHONE	COUNTIES SERVED
1 Illinois Michigan	Jean Downs	INXIXRegion1@dxc.com	(317) 488-5071	Dekalb, Elkhart, Fulton, Jasper, Kosciusko, LaGrange, Lake, LaPorte, Marshall, Newton, Noble, Porter, Pulaski, St.Joseph, Starke, Steuben, Whitley Chicago, Watseka Sturgis
2 Illinois	Shari Galbreath	INXIXRegion2@dxc.com	(317) 488-5080	Allen, Adams, Benton, Blackford, Cass, Carroll, Clinton, Delaware Fountainm Grant, Howard, Hutington, Jay, Madison, Miami, Montgomery, Randolph, Tippecanoe, Tipton, Wabash, Warren, Wells, White Danville
3	Crystal Woodson	INXIXRegion3@dxc.com	(317) 488-5324	Boonem Hamilton, Hendricks, Johnson, Marion, Morgan
4 Kentucky	Ken Guth	INXIXRegion4@dxc.com	(317) 488-5153	Clay, Crawford, Daviess, Dubois, Gibson, Greene, Knox, Lawrence, Martin, Orange, Owen, Parke, Perry, Pike, Posey, Putnam, Spencer, Sullivan, Vanderbirgh, Vermillion, Vigo, Warrick Owensboro
5 Kentucky Ohio	Virginia Hudson	INXIXRegion5@dxc.com	(317) 488-5186	Bartholomew, Brown, Clark, Dearborn, Decatur, Fayette, Hancock, Henry, Jackson, Jennings, Monroe, Ohio, Ripley, Rush, Scott, Shelby, Switzerland, Union, Washington, Wayne Louisville Cincinnati, Harrison, Hamilton, Oxford
	Judy Green		(317) 488-5026	All other out of state areas not previously listed
Team Lead	Jenny Atkins		(317) 488-5032	

Helpful Tools

IHCP website at in.gov/medicaid/:

- *IHCP Provider Reference Modules*
- *Medical Policy Manual*
- Contact Us – Provider Relations Field Consultants

Customer Assistance available:

- Monday – Friday, 8 a.m. – 6 p.m. Eastern Time
- 1-800-457-4584

Secure Correspondence:

- Via the Provider Healthcare Portal

  *(After logging in to the Portal, click the **Secure Correspondence** link to submit a request)*

Questions

Please review your schedule for the next session you are registered to attend

Session Survey

Please use the QR code or the weblink below to complete a survey about the session you just attended. Each session has a unique survey so be sure to complete the appropriate one for each session you attend. We will be taking your feedback from this survey to improve future IHCP events.

https://tinyurl.com/fssa1065